**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

DAVID B WILLINGHAM MD
4222 WENDOVER STE 600
ODESSA TX 79762

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
#54

**MFDR Tracking Number**
M4-12-2492-01

**MFDR Date Received**
MARCH 30, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** A position summary was not submitted by the requestor.

**Amount in Dispute:** $170.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor is in the Texas Star Network. Texas Mutual claimant 99M0000653560 is in the same network…Clearly, the requestor's request for medical fee dispute resolution does not meet the applicability criteria of 133.307…"

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E Highway 290, Austin, TX 78723

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 24, 2012 | CPT code 99214<br>CPT code 99080-73 | $135.00<br>$35.00 | $0.00<br>$0.00 |
| TOTAL | | $170.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 20, 2012
   - CAC-B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-150 – PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.

- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 248 – DWC-73 IN EXCESS OF THE FILING REQUIREMENTS; NO CHANGE IN WORK STATUS AND/OR RESTRICTIONS; REIMBURSEMENT DENIED PER RULE 129.5
- 728 – THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824
- 890 – DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS.

**Issues**

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?

**Findings**

1. §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care **not** [emphasis added] delivered, or arranged by a certified workers" compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Tex. Admin. Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Out-of-network health care is addressed at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Health Care*. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. This dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307; for that reason, no additional reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | February 15, 2013<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to:

Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.